LOUISIANA ARTHRITIS AND RHEUMATOLOGY PATIENT REGISTRATION

Patient's Full Name:_____
(Last) (First) (MI)

Single ❑ Married ❑ Divorced ❑ Widowed ❑ Date of Birth:_____ SSN:_____

Mailing Address:_____ Physical Address: _____

City:_____ State:_____ ZIP:_____ Male ❑ Female ❑

Home Phone:_____ **Work** Phone:_____ **Cell** Phone: _____Email:_____

❑ I give my permission to be contacted by Email

Employer:_____ **Address:**_____**Yrs Emp:** _____

Emergency Contact (Outside the home) Name:_____ Relationship: _____Phone:_____

Responsible Party:_____Relationship:_____

Address:_____ City:_____ State:_____ ZIP:_____

Date of Birth:_____ **SSN:**_____ Male ❑ Female ❑

Employer:_____Yrs Emp:_____ Work Phone:_____

Referred By:_____ Is this visit related to an injury? Yes ❑ No ❑

Date of Injury:_____ Place of Injury:_____

Workers Comp Carrier:_____ Adjuster:_____ Claim#:_____

Is this visit subject to payment for a Liability Claim? Yes ❑ No ❑ Carrier: _____

Primary Care Physician (PCP): _____ Phone #:_____

Primary Insurance:_____ Address:_____

Member Name:_____Policy #:_____ Group #:_____

Member Date of Birth:_____ SSN:_____Employer:_____

Secondary Insurance:_____ Address:_____

Member Name:_____Policy #:_____ Group #:_____

Member Date of Birth:_____ SSN:_____Employer:_____

Tertiary Insurance:_____ Address:_____

Member Name:_____Policy #:_____ Group #:_____

Member Date of Birth:_____ SSN:_____Employer:_____

I authorize Louisiana Arthritis and Rheumatology to verify benefits and file my insurance.

SIGNATURE:_____ DATE: